

AID TO THE PHYSICALLY HANDICAPPED

H. Res. 230 - Part 2



AMERICAN FOUNDATION
FOR THE BLIND INC.

AID TO THE PHYSICALLY HANDICAPPED

HEARINGS

BEFORE THE

COMMITTEE ON LABOR

SUBCOMMITTEE TO INVESTIGATE AID TO THE
PHYSICALLY HANDICAPPED

HOUSE OF REPRESENTATIVES

SEVENTY-EIGHTH CONGRESS

SECOND SESSION

PURSUANT TO

H. Res. 230

A RESOLUTION AUTHORIZING THE COMMITTEE ON LABOR
TO CONDUCT AN INVESTIGATION ON THE EXTENT AND
CHARACTER OF AID NOW GIVEN BY THE FEDERAL,
STATE, AND LOCAL GOVERNMENTS AND PRIVATE
AGENCIES TO THE PHYSICALLY HANDICAPPED,
AND FOR OTHER PURPOSES

PART 2

AID TO VICTIMS OF POLIOMYELITIS

SEPTEMBER 8, 1944

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To Investigate Aid to Physically Handicapped



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INVESTIGATION OF AID TO THE PHYSICALLY HANDICAPPED

FRIDAY, SEPTEMBER 8, 1944

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE OF THE COMMITTEE ON LABOR,
Washington, D. C.

The subcommittee met at 10 a. m., Hon. Augustine B. Kelley (chairman) presiding.

Mr. KELLEY. The committee will be in order. The first guest witness today is Dr. Charles Armstrong.

(No response.)

Mr. KELLEY. Is Dr. Van Horn here?

Dr. VAN HORN. Yes, sir.

STATEMENT OF DR. A. L. VAN HORN, DIRECTOR OF THE DIVISION OF HEALTH SERVICES OF THE CHILDREN'S BUREAU, UNITED STATES DEPARTMENT OF LABOR, WASHINGTON, D. C.

Mr. KELLEY. Doctor, will you give your name and background for the record, please, before you begin?

Dr. VAN HORN. I am Dr. A. L. Van Horn, Director of the Division of Health Services of the Children's Bureau, United States Department of Labor.

I am a graduate of the University of Michigan Medical School. I have had 6 years of post-graduate training in the field of pediatrics. I was formerly director of the bureau of child hygiene in the State health department of Ohio. I was regional medical consultant of the Children's Bureau for 1 year and I was Assistant Director of the Crippled Children's Service in the Children's Bureau for 4 years, in charge of this service for 3 years. I am now the Director of the Division of Health Services.

I am appearing today as a representative of the Children's Bureau, and I do not speak for the administration.

Under title V, part 2, of the Social Security Act, Federal funds are made available for services for crippled children through grants-in-aid to the official crippled-children agency in each State. The official State crippled-children agency is the agency legally responsible for the treatment of "children who are crippled or who are suffering from conditions which lead to crippling." That is the wording which is in the Social Security Act.

In 29 States this official agency is the State health department; in other States it is the department of welfare, the department of education, the State university, or a special commission set up by law. The United States Children's Bureau is the Federal agency responsible for the administration of this title of the Social Security Act.

As a condition leading to crippling, poliomyelitis is thus one of the concerns of the State crippled-children agencies. I should like to point out that although it is obviously a problem of great seriousness, and is the leading cause of crippling from orthopedic conditions among children, poliomyelitis is not the only crippling condition with which crippled children agencies are concerned. In 1940, over 18 percent of the children on State crippled-children registers had crippling conditions resulting from poliomyelitis.

I might say that we have on our State registers at the present time something in the neighborhood of 370,000 crippled children under 21 years of age. The figure of 18 percent which I gave is the percentage of children on the register that are crippled as a result of poliomyelitis.

The remainder were crippled from a variety of other conditions, such as cerebral palsy, clubfoot, osteomyelitis, tuberculosis of bones and joints, rickets, and congenital malformations. The crippling effects of a single disease, rheumatic fever, are far greater than that of poliomyelitis in respect to the number of children who acquire a handicapping condition, heart disease, or who die from the disease. It is estimated, for example, that at the present time there are approximately a half million children in the United States with this disease.

Mr. KELLEY. That is, with poliomyelitis?

Dr. VAN HORN. No; I refer to rheumatic fever.

Mr. KELLEY. Rheumatic fever?

Dr. VAN HORN. Yes.

The State crippled-children agencies accept for care under their regular programs children with acute poliomyelitis and crippling conditions resulting from poliomyelitis. These programs, in brief, provide for a complete plan of treatment for crippled children, including locating children in need of care; diagnostic services, medical and nursing services; hospital, convalescent, and boarding-home care; and aftercare—medical, nursing, and social. The professional staff of the crippled-children agency usually includes qualified medical, orthopedic-nursing, medical-social, and physiotherapy personnel.

The official State crippled-children agency has responsibility for finding children who are crippled or who are in danger of becoming crippled. Epidemiological reports from local health officers are among the important sources of information used in immediately locating crippled children whether the official agency is the health department or another agency.

The interest of physicians, nurses, social workers, teachers, and the general public is stimulated in bringing to the attention of the State agency any child with a crippling condition, including those with poliomyelitis. The maintenance of a continuing rather than a sporadic case-finding service increases the likelihood that children who are not reported to health authorities during an epidemic will later become known to the official agency and brought under treatment if there is any residual paralysis.

Although with present knowledge there appears to be no effective means of preventing poliomyelitis, the crippling deformities which result from it may in large measure be either prevented or minimized. In order to accomplish this desired result, it is essential that the disease be recognized in its earliest stages and treatment instituted without delay.

Provision must therefore be made for early diagnosis and treatment by qualified physicians and other professional and technical workers. Many State agencies during epidemics of poliomyelitis have made freely available to children and to their family physicians the diagnostic and consultation services of highly qualified pediatricians and orthopedic surgeons.

Medical, nursing, and hospital care is provided by State crippled-children agencies to children with acute poliomyelitis who need such care. The State agencies utilize the services of qualified physicians and nurses and place children in hospitals where adequate standards are maintained. The children are kept in the hospital just as long as they need concentrated expert medical and nursing care. There are many social and emotional problems connected with the care of children with acute poliomyelitis, and the State medical-social consultants are enormously helpful in working out ways of keeping the parents informed of their child's progress, helping the child adjust to hospital life, preparing the child and his family for the long treatment ahead and the adjustments that may have to be made because of his physical handicap.

Of great importance are the services of the State crippled-children agencies during the period of aftercare of poliomyelitis when the results of treatment aimed at preventing or reducing residual handicap becomes known and when the child's adjustment to his handicap becomes of paramount importance. The ultimate benefit a child derives from treatment often depends in the last analysis on the help given him through the long process of adjustment to convalescence, possible limitation of activity, and emotional strains to which he is subjected in daily living with his family, at school or at work, and in his community. Hence, careful planning by the official State crippled children agency for the integration and utilization of the appropriate services from official and nonofficial agencies is essential if the individual needs of each child with poliomyelitis are to be met.

The State crippled-children agencies are responsible for the care of children with acute poliomyelitis under their regular programs, and should assume leadership for planning for the care of such children during epidemics as well. The State agencies have been urged to develop plans in advance for the handling of epidemics of poliomyelitis. State plans for services for crippled children must provide for cooperation with medical, health, nursing, and welfare groups and organizations and with the vocational rehabilitation agency. The relationships developed with these groups and the experience gained in working with them helps the official crippled-children agency to assume leadership in the advance planning for coordination of community resources of personnel, facilities, and funds during epidemics of poliomyelitis. Such community resources should be utilized to the fullest extent. Modification of some of the policies followed in the regular program of course are necessary to meet the conditions of an epidemic.

Occasionally the State crippled-children agency may be able to handle an epidemic through its regular program and budget. If, however, the agency has not sufficient funds through its own budget and other community resources, and I refer there to the resources that come through the National Foundation for Infantile Paralysis, for example, to care for all cases, additional funds may be requested from the Children's Bureau.

Some of the Federal funds are not allotted at the beginning of the fiscal year but are reserved for later allotment to States with special needs. An epidemic of poliomyelitis is recognized as a special need and additional funds needed for an epidemic of poliomyelitis have been granted by the Children's Bureau within its budgetary limitations. Only in exceptional instances have the funds provided from this source been sufficient to meet the requests made by State agencies.

In addition to funds, the Children's Bureau is prepared to offer consultation services to States with poliomyelitis epidemics. Assistance in organizing ways of meeting the situation may be given by the regional medical, public health nursing, and medical-social consultants on the staff of the Children's Bureau. Technical consultation on orthopedic nursing and physiotherapy is also available from the public health nursing consultant with special training in physiotherapy, who is on the central staff of the Children's Bureau.

The Children's Bureau also keeps a roster of State agency personnel trained in orthopedic nursing or physiotherapy and makes this information available to States in order to facilitate the temporary transfer of trained personnel to the crippled-children agency in States with epidemics of poliomyelitis.

Since the enactment of the Social Security Act in 1935, only about half a dozen States have not experienced epidemics of poliomyelitis. The incidence in 1943 was one of the highest since 1916, I believe. The incidence this year has been even higher than last year's incidence up to September. It should be understood that in comparing the number of cases reported in different years that several factors may influence the fluctuations from year to year, such as the more complete reporting of cases, the inclusion of more abortive and nonparalytic cases among those reported, variations in virulence of the virus or in resistance of the host or by a combination of such factors. With the recent widespread interest in provisions for the early care and treatment of the poliomyelitic patient and with greater emphasis being placed on the recognition of nonparalytic cases, it was not surprising that the number of reported cases showed a sharp increase during the past 2 years.

Eight States, extending through Texas and Louisiana up through Iowa and Nebraska, reported a total of over 3,000 cases last year. A conference was called last winter by the crippled-children agencies of these States to discuss some of the problems they had met in connection with the epidemic. The most important lessons which emerged from the conference were that we still have much to learn regarding the disease and the care and management of the patient with poliomyelitis, and that there is urgent need for closer coordination of the interest and activities of official and voluntary agencies concerned with the problem.

If an epidemic occurs in a State, it is of utmost importance that the afflicted children may be sent to hospitals staffed with doctors and nurses who have training in the care of poliomyelitis patients. Many State agencies have made arrangements in advance so that there will be hospitals willing and prepared to receive these patients. In New Jersey, for example, the county hospitals have agreed as to which ones may be used in an epidemic. In a number of States, such as Illinois, the State agency has worked with hospitals in a plan for giving some staff nurses in a large number of hospitals special training in the

nursing care of poliomyelitis patients. Plans have been worked out in other States for a course for volunteers and parents who might be called on to assist in hospitals in case of epidemic. The results in terms of care for poliomyelitis victims in epidemics have been gratifying during recent years. In the 1943 poliomyelitis epidemic in Kansas, for example, 98.7 percent of the 761 patients with poliomyelitis were treated in hospitals.

In closing I would like to offer two recommendations or statements regarding needs:

1. Any additional Federal appropriations for the diagnosis, care, and treatment of children with acute poliomyelitis should be through grants in aid to official State agencies now administering services for crippled children under the provisions of title V, part 2, of the Social Security Act. Care of children with poliomyelitis involves not only medical and hospital care during the acute period and during epidemics, but also long-term planning in relation to both medical and social needs. The official State agencies should continue to be responsible for the care of these children because they have established programs, professional staffs equipped to make long-term plans, and cooperative arrangements with other public and private agencies. Additional appropriations are needed for the provision of care to more children, the employment of additional professional personnel on the staffs of the State agencies, and for the training of personnel in the care of children with poliomyelitis.

2. Additional funds are needed to provide more adequate facilities for both hospital and convalescent care of physically handicapped children, including those afflicted with poliomyelitis. Many States do not have hospital facilities for children that are adequate in quality or quantity. Especially in certain regions of the country the hospital facilities for certain minority groups are grossly inadequate. There is a general need for more suitable hospital and convalescent facilities for the adolescent-age group. There are at present many States without any convalescent facilities at all, and in no State in the Union are convalescent facilities for children adequate to meet the needs.

Mr. KELLEY. Doctor, do you know how many of the victims of poliomyelitis are permanently disabled to a degree that it would handicap them in earning their living or to be independent?

Dr. VAN HORN. I certainly do not know the number, sir, that are so permanently handicapped following poliomyelitis epidemics. The epidemics vary a great deal in their severity. It is difficult for one to generalize because in some epidemics there are more individuals who are severely paralyzed than in other epidemics. The proportion of patients left with a handicapping residual paralysis varies in localities, and it varies from year to year.

I believe that it is generally felt to be true that certainly from 60 to 75 percent of those who are afflicted with acute poliomyelitis recover with little or no residual paralysis. The remaining group may be left with varying degrees of affliction, all the way from complete paralysis of the body to rather minor degrees of paralysis, perhaps afflicting only one limb or a group of muscles in one limb.

Mr. KELLEY. Where there is some paralysis, as a result of the disease, is there much progress being made in correcting that affliction, or does it usually remain permanent?

Dr. VAN HORN. I believe there is unquestioned progress being made in bringing about further improvement in the care of the individual who is left with residual paralysis.

The strides that have been made in the field of orthopedic surgery, and on which Dr. Ober can well testify, have been remarkable since the last war, and I believe that the results of the care that has been provided by the orthopedic surgeons in this country will testify to the excellent work that is being done in bringing about as nearly complete rehabilitation of the patient as is possible.

Mr. BARKER. Doctor, there is such a woeful lack of knowledge about this disease, both among laymen and, as I understand it, among physicians also. I wonder if you would tell us what is the most practical thing for a parent to do in the usual case where the parent is informed that his child has poliomyelitis. That is, take that child and tell us what facilities are likely to be available in a typical case, and what should be done.

Dr. VAN HORN. I think it is largely a matter of equipping the parent to accept emotionally and psychologically a situation which, to them, at the moment, may seem as a calamity that has occurred to their particular child. It is a matter of reassuring the parents that the facilities and services that are available at the present time, in the United States for the care of patients with poliomyelitis are, perhaps, better developed in this country than in any place in the world, and that they do have the opportunity of getting the most complete physical restoration that is possible for the child.

It is, I think, largely a matter of explaining patiently to the parents of any child having a severe paralysis that he is likely to have a permanent paralysis with deformity, that they must accept it, and that it is a matter of developing the child's physical assets, and disregarding the deformity as limiting the child in any way other than, perhaps, some degree of restriction in physical activities.

Mr. BARKER. Well, what I meant more particularly is if the parents do not have a great deal of money, are all of these facilities available for the care of their child through Children's Bureau grants?

Dr. VAN HORN. Yes.

Mr. BARKER. And they can get those, they get hospitalization and get the care furnished by the social-security law that is in effect today?

Dr. VAN HORN. Yes; that is true in the vast majority of States.

To my knowledge, no State agency has ever denied care to a child or to the parent of a child afflicted with poliomyelitis. We do know that, due to certain restrictive legislation in certain States, some parents, perhaps, would be considered as being financially able to provide for the service and that their child might not be eligible for the service that would be available under State programs.

There are a few State laws which restrict the services to the group that are termed as indigent. However, to my knowledge, I do not know of an instance where a State agency has denied care to a child because of any restrictions in financial eligibility; however, in some States having severe epidemics the funds made available through the State agency have not always been sufficient to meet the total needs.

Mr. BARKER. Doctor, can you tell us on the basis of the figures that you may have at what age this disease is most likely to occur?

Dr. VAN HORN. I think, without question, the vast majority of those who are afflicted are under 10 years of age. As we go up through the various age groups the incidence becomes less than in the lower age groups. It is primarily a disease which affects children.

Mr. BARKER. Would you tell us what research facilities are available in the country today, that is, some of them in this field?

Dr. VAN HORN. In the Federal service, there is, of course, the outstanding work that has been carried on at the National Institute of Health under the excellent direction of Dr. Armstrong, who is here today.

For a number of years there has been experimental and investigative study carried on in the United States in our research centers, located in universities and in certain State health agencies for the study of the virus of poliomyelitis.

Through the excellent work that has been done with the funds made available through the National Foundation for Infantile Paralysis there has been a great deal of stimulus given to research work in the study of poliomyelitis. I have seen the list of centers that are engaged in this work and I think probably Dr. Gudakunst could give you a great deal more in detail. I know among them are such research centers as Johns Hopkins University, the University of Pennsylvania, the University of Michigan, the University of Minnesota, and I am sure that there are many others that he could name that are also engaged in active research in this field.

Mr. BARKER. Is it possible to give us any estimate of how long the disease remains with a person?

Dr. VAN HORN. The initial stage of acute illness, usually lasts from 10 days to 2 weeks. A child who is afflicted with poliomyelitis may recover without any residual paralysis. That recovery may be within a period of weeks, it may be within a period of a few months. It has been demonstrated that those who are left with residual paralysis usually will show the maximum amount of recovery within a period of 18 to 24 months after the initial disease, that is, after they have been attacked. In individual instances I believe further evidences of recovery have been noted beyond that period of time. The individual may, depending upon the degree and extent of the affliction, be in need of further orthopedic surgery for the correction of a resulting deformity or perhaps the fitting of some necessary appliance in order that that individual may function more normally in the use of his limbs.

Mr. KELLEY. Dr. Van Horn, I believe you made the statement that there are 374,000 crippled children under a certain age; was that under the age of 21 or 15?

Dr. VAN HORN. That is under 21 years of age.

Mr. KELLEY. And 18 percent of those who are crippled is due to affliction of poliomyelitis?

Dr. VAN HORN. Yes.

Mr. KELLEY. That would be something like 67,000 of them?

Dr. VAN HORN. Yes.

Mr. KELLEY. In varying degrees of handicap.

Dr. VAN HORN. That is right. These 67,000 patients may represent individuals who have only recently been afflicted with the disease and it may represent those who have a residual paralysis and have had it for a number of years but are under 21 years of age. Following

epidemics of poliomyelitis there are a constant number being called to the attention of the State agencies, of children who were not known to have had infantile paralysis at the time of the epidemic. They may have lived in some remote section of the country, with little or no medical care or where they were seen by physicians who perhaps may not have recognized it as being that disease. Such children frequently appear later with rather severe deformities, and it is usually these missed cases that represent those where there is a great deal of work that needs to be done in order to bring about a satisfactory degree of physical restoration.

Mr. KELLEY. Of these 67,000, how many would you say could be restored to their normal life and how many will be so severely handicapped that they cannot be restored to productive work?

Dr. VAN HORN. We do not have that information, sir.

Mr. KELLEY. Are there agencies in the Nation that attempt to do this, or are they neglected after that?

Dr. VAN HORN. The Federal Office of Vocational Rehabilitation is the agency responsible for the administration of that particular program. The program is adapted so as to meet the needs of any individual, no matter how severely handicapped he may be. For example, when a child reaches the age of 16 and is known to still have residual paralysis or a deformity resulting from this disease, he is referred to the State vocational rehabilitation agency for counsel and advice with respect to a vocational program that can be worked out for him.

This is done in conjunction with the advice and recommendation of an orthopedic surgeon, of the medical social worker who may have worked with that particular individual and with the counsellor of the Vocational Rehabilitation Agency. Every effort is made to bring about the greatest degree of physical restoration to make the handicapped person a self sustaining individual within the community, who is not dependent upon the community, but who is able to earn his own livelihood.

Mr. KELLEY. What is the rate of mortality of the victims of poliomyelitis?

Dr. VAN HORN. It varies with the epidemic, sir. Some epidemics have been more severe than others. I believe that the usual range is around 8 to 12 percent.

Mr. KELLEY. We are glad to have had you with us, Dr. Van Horn.

Dr. VAN HORN. Thank you.

STATEMENT OF DR. CHARLES ARMSTRONG, MEDICAL DIRECTOR, UNITED STATES PUBLIC HEALTH SERVICE

Mr. KELLEY. Dr. Armstrong, we will be glad to hear you. Will you give us your full name and the capacity in which you appear?

Dr. ARMSTRONG. My name is Charles Armstrong. I am a graduate of Johns Hopkins University; Medical Director of the United States Public Health Service, and at present I am Chief of the Division of Infectious Diseases in National Institute of Health of the United States Public Health Service.

I am wholly unfamiliar with your procedure at these hearings, Mr. Chairman, consequently I have brought no prepared statement.

Mr. KELLEY. If you care to make a statement the committee will be glad to have it and then probably may wish to ask you some questions.

Dr. ARMSTRONG. I would preface what I have to say by making it clear that I am not a clinician. My work in poliomyelitis has been in the field of experimental research and I am not in position to answer many of the questions regarding rehabilitation which I have heard asked here today. However, I do feel that your program is perhaps deficient in certain regards. It seems to me that it perhaps would be better to build a fence at the top of the cliff to keep people from falling off rather than to hold an ambulance ready at the bottom to pick up the bodies after they have fallen. That is, I feel that research aimed at prevention and at the cure of the disease during the attack should be pursued in order to prevent these crippling diseases, and I regard that of equal importance, if not more important than the mere program of rehabilitation.

Mr. KELLEY. Of course, we are interested in that, the prevention and cure as well as rehabilitation.

Dr. ARMSTRONG. Yes.

Mr. KELLEY. We are interested in the whole phase of it.

Dr. ARMSTRONG. Yes. But it is rather an embarrassing situation because I do not believe that research in this disease is suffering at the present time for want of funds. The National Foundation for Infantile Paralysis at the present time, at least in its last report, had over \$3,000,000 of fluid assets which it is willing and anxious to put at the disposal of research workers in this field. What really is needed are ideas or experimental leads and if there is any individual with an idea that is practical, or that should receive study I have no question but what that money could be found. Our experience in the Public Health Service has been that when we had a promising idea we have received sympathetic hearing when we have come to the Appropriation Committees in the Congress: they have received us sympathetically and our requests have been liberally considered. I feel, however, that too much money might be a drawback in such a program. I have had research workers in the last year tell me that they thought they would get out of the poliomyelitis field, that there were too many people in it, there was too much fuss and too much publicity. Money will attract a certain group of people, but there is another type of person that will be discouraged and driven into other fields.

Then I feel that we should maintain a proper perspective of this thing. The biggest known outbreak or epidemic of poliomyelitis the world has ever had took place in 1916 in this country when there were 27,363 cases reported, and about 90 percent of those were paralytic.

Mr. KELLEY. How many?

Dr. ARMSTRONG. About 90 percent. It may well turn out that this year will be the largest epidemic since 1916 in this country. Dr. Ruhland has just told us that in the District of Columbia 40 percent of the reported cases were of a nonparalytic type so we see that increasing numbers of nonparalytic cases are being reported today so that the number of cases that are being reported today does not necessarily mean that we have a comparative measure with the previous epidemic. In ordinary years when poliomyelitis has been usually prevalent, you might expect six or seven thousand cases and a portion of them will be nonparalytic.

There are other crippling diseases and Dr. Van Horn has previously mentioned them, which are of much more importance than poliomyelitis.

These are the few remarks that I believe I wish to make and if I can answer any questions I will be glad to do so.

Mr. KELLEY. Apparently there are various other sources of disability to children who are under 21, because out of the 374,000 cripples, 67,000 are the result of poliomyelitis, so that something like 82 percent of the 374,000 come from other diseases.

Dr. ARMSTRONG. Yes.

Mr. KELLEY. So it is a problem.

Dr. ARMSTRONG. Yes.

Mr. KELLEY. We are interested in the whole problem of seeing what could be done for those who have been unfortunately afflicted, and not only from poliomyelitis.

At present we are devoting the time to this particular field.

Dr. ARMSTRONG. I have no doubt there is a need for additional rehabilitation, but I do not feel that I am clinically qualified to pass judgment on it.

Mr. BARKER. Dr. Armstrong, how effective are the measures to prevent poliomyelitis today? For example, I think one general conception is that children should be kept away from swimming pools. Has that been a very effective method of prevention?

Dr. ARMSTRONG. There is no evidence to the effect that it has been very effective, because it is very difficult to get the type of information that you have asked, that is, to know just what would have happened if the child who develops polio after swimming had not gone swimming, that is, whether poliomyelitis would have developed or not. How poliomyelitis is transmitted from one individual to another is not yet definitely established and until this point is cleared up it is extremely difficult, and I think impossible to give a definite answer to your question. My own feeling is that the measures we have are not very effective. They are the best we have and we must use them, but they are not ideal.

Mr. BARKER. Is there any satisfactory proof that allowing children to go to a swimming pool will make the child more susceptible to the disease?

Dr. ARMSTRONG. Well, that is also a hard question to answer; it is difficult to ascertain. In the history of the individual case you will often find instances where you get a history that the child, a day or two before the attack took a great deal of exercise, took a long bicycle ride, or played some strenuous game, and there is a feeling that the overexercise may probably have made the child more susceptible to the disease. Of course you can overexercise in a swimming pool and you come in close contact quite often with a lot of people in a swimming pool and the water may be contaminated with the sputum, nasal secretions or intestinal discharges which are known at times to contain the virus of infantile paralysis and it would appear theoretically possible for the virus to thus be transferred to healthy bathers.

Mr. KELLEY. There is also some connection with the season of the year and the epidemics which usually occur in the summer. We do not have them in the winter.

Dr. ARMSTRONG. It is true that the great majority of outbreaks have occurred during the summer, and that they start in the south and as the hot weather proceeds north, the poliomyelitis proceeds north. However, there have been in the neighborhood of 50 epi-

demics that occurred in the wintertime. One at Elkton, W. Va., in 1917, occurred when the temperature was around zero.

Mr. KELLEY. Is there an area on the earth where they have never been afflicted with this disease?

D. ARMSTRONG. Presumably if there are people there they have had polio.

Mr. KELLEY. Yes.

Dr. ARMSTRONG. Wherever there are people, as far as I know, there is evidence of poliomyelitis cases.

Mr. KELLEY. There is no climate or condition that you know of that has had had poliomyelitis?

Dr. ARMSTRONG. Evidence of the infection is found wherever people live, and it is found whether the sanitary conditions are very poor or good.

Mr. BARKER. Children get it much more than adults? Is there an explanation for that?

Dr. ARMSTRONG. Well, up to 1 year of age children are relatively not as susceptible as they are after 1 year up to 5 or 10, then susceptibility begins to fall off again. The explanation that is accepted by most people is that children are exposed to the virus and that they do not succumb to a definite attack of the disease but that they do acquire immunity just as happens with diphtheria.

Mr. KELLEY. It is just a matter of time when something is discovered, something is found that will be effective against the disease?

Dr. ARMSTRONG. We hope so; we hope that it will be.

Mr. BARKER. Dr. Armstrong, how do we compare in this country with the other countries?

Dr. ARMSTRONG. Unfortunately the United States is the worst known sufferer from poliomyelitis.

Mr. BARKER. Do they have a different form of treatment in the other countries than we?

Dr. ARMSTRONG. Well now, you had better ask some of the clinicians; but I do not believe that the differences in incidence in different countries is a result of method of treatment. Often those countries that have less sanitation, less public health, apparently suffer less from poliomyelitis than those with more advanced sanitary measures, and very often in cities the poorer sections suffer less severely than do the well-to-do sections. And often children in the cities suffer less than children in the rural sections. These are mysteries we cannot yet definitely explain.

Mr. KELLEY. At least today? We thank you very much, Dr. Armstrong. We are glad to have had your help.

Dr. ARMSTRONG. Thank you.

STATEMENT OF DR. FRANK OBER, PROFESSOR OF ORTHOPEDIC SURGERY, HARVARD MEDICAL SCHOOL

Mr. KELLEY. Dr. Ober is our next witness.

Dr. OBER. Mr. Chairman, I do not have a prepared paper. Dr. West asked me if I could come down to the hearing.

Mr. KELLEY. We are interested at this time in poliomyelitis.

Dr. OBER. I have been interested in it for more than 30 years.

Mr. KELLEY. You might give us your full name and some of your background.

Dr. OBER. Frank R. Ober, Boston. I am John B. and Buck Minster Brown clinical professor of orthopedic surgery at the Harvard Medical School; assistant dean in charge of the courses for graduates at the same school, orthopedic surgeon in chief at the Children's Hospital in Boston, and of the New England Peabody Home for Crippled Children; surgeon in charge of the Vermont infantile paralysis work for over 20 years; adviser to the State program for crippled children in Massachusetts, Department of Public Health, and also consultant to that department; member of the council of physical therapy of the American Medical Association; member of the Advisory Committee Group Foundation; member of the National Foundation for Infantile Paralysis, and chairman of the Harvard Infantile Commission.

My work is concerned primarily with the work of rehabilitation and teaching.

Mr. KELLEY. Will you tell us something of your work in rehabilitation, Doctor?

Dr. OBER. For 25 years, since 1916, I was associated with the late Dr. Robert W. Lovett who is still highly regarded for his work in poliomyelitis. Under his direction I worked on the Massachusetts poliomyelitis clinic in 1916.

I have also managed the surgical end of the Vermont infantile paralysis work. It is estimated that we have gotten 400 people out of wheel chairs in the State of Vermont in the last 25 years. A great many helpless cripples have been put on their feet and made self-supporting.

As Dr. Van Horn said, the degree of poliomyelitis varies. You may have a patient who has two paralyzed thumbs. It is very difficult for that patient to write, to turn pages, or to fasten his clothes; or the patient may have paralysis of both legs, or both legs and both arms. It varies. It is like playing a game of bridge: You draw a different hand every trip. Sometimes you can have a poor hand and make the game. A patient afflicted with poliomyelitis may have a large amount of paralysis but it is distributed in such a way that he can still function, that is, he can get around very well.

When it comes to total disability it is very rare. A great deal of total disability may present psychological problems. I do not believe anyone would say that the President of the United States is totally disabled although his two legs are disabled.

It is a question, in the early stages, of excellent nursing to relieve the painful symptoms and to prevent the deformities. After the painful symptoms have disappeared then active methods can be applied toward a restoration of the functions and the improvement of muscles, and that is done by physiotherapy, under the treatment in the majority of cases, under the direction of a doctor who knows the problems.

This treatment may go on indefinitely. The maximum recovery is usually within 12 to 24 months, but I have seen some recovery of power in muscles take place after 25 years. Therefore when we consider the problem from the rehabilitation point of view, it is a long drawn out problem. Some patients who are paralyzed completely recover during the acute stage. Some may completely recover in 12 months, some may make a complete recovery in 2 years, and if they do not completely recover in that period it is probable they never will.

The peculiar effect of the disease is the acquirement of deformity. A child 2 years of age may have poliomyelitis and make apparently a complete recovery, and at the age of 10 or 12 years may develop a severe curvature of the spine, so that any child who has had poliomyelitis should be followed for an indefinite period.

For some time at the Children's Hospital in Boston, we have been educating technicians in physical therapy in the management of poliomyelitis. At present we have 31 women who are going to take the course. They go out all over the country and take care of patients with all sorts of disabilities including infantile paralysis. This school has been going since 1920. Under the emergency plan of the Surgeon General's Office, we are training other groups of physical therapists. These women have to be nurses with a good background or they will have had 2 years of college training, a portion of which has been devoted to the sciences, basic sciences, so that we are producing a group of women to go out into the field to take care of poliomyelitis.

In Vermont the work on poliomyelitis has been going on since 1914. Each clinic has brought in not only poliomyelitis cases, but all sorts of other crippling diseases.

We also ran epidemiology work under the Rockefeller Foundation until that was transferred to the Harvard Infantile Paralysis Commission in 1920. We began vocational occupational therapy in 1921 or 1922—I am not quite sure of the date—and that has improved until now we have a vocational bureau with a director, who goes around hunting up the handicapped people in the State of Vermont who are unable to do anything and they try orthopedic measures to restore those people to a working life. They pay their hospital expenses and a small fee to the surgeon who operates on the patients and takes care of them afterward.

A great many patients with infantile paralysis have operations to lengthen a short limb, or to shorten a leg that is too long, or to inhibit the rapid growth of a longer leg; and operations for stabilizing joints. But all the patients who wear apparatus continue to require some orthopedic surgical treatment in order to see that they are wearing the proper braces, and that they are kept in proper repair. That means that we need proper brace shops. There is a dearth of brace shops in this country. There is a dearth of brace-shop workers. The trained brace man is much the same as a trained watchmaker. Our shop at the Boston Children's Hospital is understaffed. Most of these brace makers are *prima donnas*, and it is difficult to get trained personnel. It would be helpful if we could take some of these handicapped boys, who have been handicapped by poliomyelitis, who are mechanically minded, and train them in the making of braces. They would be more sympathetic toward the fellow cripple than some of the men who simply say, "We will make you a brace and have it ready 6 months from now," when you need it tomorrow.

The Massachusetts Infantile Paralysis Commission has a central clinic in the Children's Hospital in Boston which has been going on since 1916. We have a director of the clinic and he has an assistant who serves 1 year. Those assistants go out to some other university and they are replaced by some other man to be trained, so that we will have men familiar with the care of poliomyelitis. This clinic runs 3 mornings a week with two doctors in charge and a group of physiotherapists take care of the patients, give them exercise and

teach the mothers how to apply them to and use it on their own children, which works very well.

There are 11 subsidiary clinics that go into towns, which for the most part are not covered by the State and Child Labor Bureau program. I may be corrected but I think that the Child Welfare Labor Bureau, or whatever it is called under the State program, does not cover the large communities. For instance, Boston is not covered by the State welfare commission, or any other large city; only the smaller towns.

The orthopedic surgeon who goes out on this State clinic is sent by the State commission of health, subject to the approval of the advisory committee, so that we pick the best men that we can get. A group of consultants is picked by the State commission of health for an advisory committee, and these consultants go out and observe how the men are running the clinics and doing their work.

We have research work going on at the Massachusetts General Hospital on bone growth, carried on by grants from the National Foundation Fund for Infantile Paralysis. A year ago we had a grant given to the Children's Hospital under Dr. Bronson Crothers to study the psychological problems of poliomyelitis and with a particular view to taking care of this program which has not been done before.

Mr. KELLEY. Dr. Ober, you made the statement that you have taken 400 patients out of wheel chairs in the State of Vermont.

Dr. OBER. Yes.

Mr. KELLEY. That is in one State?

Dr. OBER. Yes.

Mr. KELLEY. Have you any idea what percentage that would be of those who were in wheel chairs?

Dr. OBER. Well, that is most of them.

Mr. KELLEY. The most of them?

Dr. OBER. The patient who has good arms, and a normal back can be taught to get out of a chair and go up and down stairs, and that makes him independent. If a man can get out of the chair and can go up and down stairs he does not have to be pushed around in a wheel chair.

Mr. KELLEY. I think that it is quite remarkable, that you have been able to get out of wheel chairs some 400; that is a vast number.

Dr. OBER. Those that are treated in the early stages of paralysis often are cured. I remember distinctly a girl I had who walked around on the soles of her feet and hands, through the years, and she is now walking around with only a brace on her foot. We had another girl who could not walk at all; she could just turn her hands, and she has so improved during the years that she gets around with a brace.

I had another girl who required an operation and who is now handling needles with the greatest of facility. She is making a good living.

Mr. KELLEY. That is remarkable.

Dr. OBER. There are some very few people who do not respond. I recall one boy who had been paralyzed for 24 years, was in a wheel chair, and when we got him out he went home and sat down and did not want to do anything. Once in awhile that happens.

Mr. KELLEY. He had been sitting down so long that he could not do anything, he thought? It was mental?

Dr. OBER. Yes. He is the only one I know who failed to respond. That is a mental situation.

Mr. KELLEY. Because it has been going on over a period of years?

Dr. OBER. Yes; but I recall one patient who had been in a wheel chair for 29 years who is now able to get around with only a pair of braces.

Mr. KELLEY. Of course, the work that you are doing is confined to Massachusetts and Vermont particularly, I suppose?

Dr. OBER. Well, my patients come from all over the world.

Mr. KELLEY. All over the world?

Dr. OBER. Yes.

Mr. KELLEY. There are other institutions, I suppose, throughout the United States that are doing comparable work to the work you are doing at Boston?

Dr. OBER. Yes. There are several hospitals in New York. Practically every large center has a place. Even out in a little city like Des Moines, Iowa, they have a successful program.

Mr. BARKER. I do not suppose the facilities in relation are sufficient to take care of 374,000 patients—the facilities are adequate now?

Dr. OBER. Well, with the war on the difficulty is getting orthopedic surgeons, but we are getting along as best we can. A statement was made a short time ago before one of the committees that Vermont was one of the States where they were not taken care of. But we have taken care of it. We have been running in these clinics treatment by physiotherapy. This year we had over 512 crippled patients in the clinics. Last year I believe it was 740, the largest we ever had. Most of the operating cases report during the summer. Most of the orthopedic surgeons are in the Army and when they get back from the service we can carry on the work more successfully.

Mr. KELLEY. I see so many crippled in my own district, up in Pennsylvania.

Dr. OBER. Yes.

Mr. KELLEY. And I am wondering—this is the western part of Pennsylvania—I am wondering if they have had an opportunity, or whether they have the knowledge of where they could go to be aided, or if they do not have the funds where they could apply for assistance.

Dr. OBER. Pennsylvania has a wonderful set-up for taking care of the crippled.

Mr. KELLEY. Yes.

Dr. OBER. All over the State.

Mr. KELLEY. Yes.

Dr. OBER. There are a lot of people who do not want to be treated.

Mr. KELLEY. Some of them do not know where to go.

Dr. OBER. Yes; that is true.

Mr. KELLEY. I think maybe that accounts for some of them.

Dr. OBER. The lack of publicity, perhaps. In the sparsely populated States like Nevada and Wyoming they could be covered by airplane service beautifully. Iowa is covered by ambulance service.

Mr. KELLEY. Someone suggested sometime ago, I think it was Congressman Voorhis, that the Federal Government should publish a booklet to be distributed by some agency that would give the information to everybody, where they could go to get aid and assistance.

Dr. OBER. I know in Massachusetts the last legislature enacted a law—I think it was the last one—that the doctor who attended a woman at childbirth should record any crippled condition that was present, any deformity that was present at birth, and until that is done in all the States we will never know how many crippled there are in the United States.

Mr. KELLEY. That would take care of those that were born crippled.

Dr. OBER. Yes.

Mr. KELLEY. But it would not take care of those who were crippled because of some injury.

Dr. OBER. All poliomyelitis cases are supposed to be reported to the State department of health, but, some diagnoses are missed; they are diagnosed as osteomyelitis and the poliomyelitis may never be reported.

Mr. BARKER. What is the average cost of the treatment of a patient who comes to you?

Dr. OBER. Well, I do not know. You mean the private patients or the attended patients?

Mr. BARKER. Maybe I should phrase the question differently.

Mr. KELLEY. You mean what would be the cost of treating someone?

Dr. OBER. We take any patients. Patients who can afford to pay are supposed to go to private doctors and not to clinic doctors.

Mr. BARKER. Who pays for the transportation and care of the patients now, Doctor?

Dr. OBER. That comes out of the budget for crippled child work of the State.

Mr. BARKER. That is out of the budget that was set up as the result of the establishment and operation of the social security work in the Children's Bureau?

Dr. OBER. Yes.

Mr. BARKER. What proportion of patients that come to the clinics are patients who pay for the treatment out of their own funds?

Dr. OBER. We will take any patients at any clinic and give them advice. They will pay nothing for that. Sometimes some patient has some extra money and he will contribute \$5, \$10, or some other amount for the work. Then they find out how the clinics are run and what such people are doing, and that is where the difficulty comes; if they contribute something for the work then they want to have our undivided attention. If they want that they have to pay for it.

Mr. BARKER. I would like to know, Doctor, whether the cost of this treatment is so prohibitive that it is not available to a substantial number of people who are suffering from the disease?

Dr. OBER. It is available to everybody.

Mr. KELLEY. If they open a clinic it will be available to everybody.

Mr. BARKER. Are facilities of the clinic adequate to take care of the patients?

Dr. OBER. Yes.

Mr. BARKER. That is true with respect to your clinic, and it is true in Massachusetts?

Dr. OBER. Yes; it is true in Massachusetts.

Mr. BARKER. Would you also say that is true throughout the country?

Dr. OBER. I do not see why not. I helped to run clinics in New York State in 1916.

Mr. BARKER. I believe Dr. Van Horn said the facilities were not adequate throughout the country, and you have also said that in certain States in the West they were not adequate because of the great distances and the sparse population. Would you recommend that regional clinics be set up in those areas?

Dr. OBER. It seems to me that is the way to take care of it.

Mr. BARKER. To what degree is it possible to continue the education of a child affected with poliomyelitis, that is, the child's general education?

Dr. OBER. Patients in medical schools have it.

Mr. BARKER. I mean after a child has just been attacked by the disease, for how long a period of time is that child in a position to continue his general education?

Dr. OBER. He can get a general education with tutoring after his acute symptoms have subsided.

Mr. BARKER. That requires some private expenditure?

Dr. OBER. In Massachusetts that is being handled now—

Mr. BARKER. By the State.

Dr. OBER. I think that is true in the towns. At the New England Peabody Home for Crippled Children, they are teaching pupils who are handicapped by crippling conditions. We have adequate convalescent facilities in the State of Massachusetts for taking care of those people. The New England Peabody Home takes cripples from all over New England.

The State of Vermont is trying to raise money so that they may be able to provide a place for convalescents near the university at Burlington.

We cover all of New England.

Mr. KELLEY. Thank you very much, Doctor, for coming in and giving us your opinion on these matters. You have been very helpful.

The next and last witness we will hear this morning is Dr. Gudakunst.

Doctor, will you give us your full name and tell us about your background, and your position?

STATEMENT OF DR. DON W. GUDAKUNST, MEDICAL DIRECTOR, THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

Dr. GUDAKUNST. Mr. Chairman, my name is Don W. Gudakunst; I am a graduate of the University of Michigan Medical School and am Medical Director of the National Foundation for Infantile Paralysis.

I have previously been a State health director, deputy health commissioner of a large city, and director of a large city school health service.

I have no prepared statement, Mr. Chairman, but I would like to tell you something about the National Foundation for Infantile Paralysis, which has been repeatedly referred to this morning.

The National Foundation for Infantile Paralysis was incorporated as a foundation in 1938.

Prior to that time, for several years, many of the essential functions now run by the foundation were in operation under a special Commission appointed by the President. Funds have been raised for the purpose of carrying on a fight against this disease for the past 11 years. To quote from the words of the President when he sponsored the establishment of this Foundation.

The general purpose of the new Foundation will be to lead, direct, and unify the fight on every phase of this sickness.

The National Foundation engages in all the activities that fall in this field. It does confine its work to infantile paralysis and activities that have a direct bearing upon that disease. It has branch organizations or chapters covering 3,000 of the counties of the Nation. Funds are raised from the people by voluntary subscription each year.

Over a period of 11 years that such funds have been raised a total of nearly \$30,000,000 has been collected—\$29,562,742.54, to give you the exact figure.

Of this sum about \$16,000,000 was raised during the past 2 years. More than half of all this money, nearly \$15,000,000 has remained in the counties, for their use, for the general medical care of patients suffering from poliomyelitis. The other half has gone to National Foundation headquarters for the purpose of carrying on the program of research and general and specialized education in respect to this disease and for emergency aid to any of the areas suffering from epidemics.

The funds of the chapters are used at the discretion of the chapters upon the advice of the local people to provide hospitalization and medical care and nursing care and to assist in equipping the hospitals so they can give this special care for poliomyelitis patients.

This care is given to all patients of all ages, regardless of race, creed or color, and it is available in all parts of the United States.

The chapters do not use their funds for research programs, or for general, Nation-wide educational programs. Obviously, the latter would be impossible and the first would lead to confusion and lack of unification of activities. The national organization supports, through grants, research programs.

During the period since its organization in 1938 nearly 300 individual grants have been made. These have been made to something over 100 groups of workers in 74 different institutions. I give those figures because that shows that it is rather widespread and it is not centralized in any one place.

The foundation does not have and does not maintain its own research center; it rather subsidizes in any way that might be needed, the operation of programs in universities, medical schools, laboratories, educational organizations and other institutions throughout the country.

During the last fiscal year of the foundation approximately something over a million and a quarter dollars were granted for research and education. We do not have an exact figure of the amount of money the chapters spent for medical care. That would call for considerable detailed bookkeeping.

Mr. KELLEY. A chapter is located in each county?

Mr. GUDAKUNST. Ordinarily on a county basis. In a few States we do have State chapters with branches in the counties, but ordinarily they are on a county basis.

The program of research is as comprehensive as medical advisers know how to make it. It embraces work in studying the nature of the virus which causes the disease and its method of spread from person to person, the method of elimination from the body; how it might be transmitted; how it enters the body; and then a study of the effects it has upon the body and cells, once this virus gains admission to the body; and attempting to find some means of putting a block in the way of its spread, or preventing its entrance to the body. Also we are trying to find some chemical or serum that will kill the virus once it enters the body.

We have engaged also in rather broad studies in the field of physiology attempting to learn more about the normal functioning of nerve and muscular tissue so we can understand the disease process better.

Rather extensive programs have been established in the field of physical medicine. The treatment of this disease is today of necessity something other than a specific drug or serum, and we have come to rely upon physical therapy rather than surgery alone. The foundation has therefore engaged upon a program involving the improvement of the practice of physical medicine. In carrying out this broad program it has set up research and study centers in most of the leading universities.

It also has a training program for technicians, physical therapy technicians, offering scholarships to students who enter this field and giving subsidies or grants to schools for training and teaching these very essential workers.

Also, we provide for postgraduate training for physicians and nurses. As has been explained much of the aftercare of poliomyelitis, falls into the hands of the nurse, she may find the need for additional postgraduate training. That we have attempted to provide. We have set up a program of postgraduate instruction for physicians in the more modern method of diagnosis and treatment.

We have also set up centers for training of research workers so we might have a more nearly adequate flow of young men into the virus-research laboratories. We are also providing training for health officers and public health workers to aid them in their effort to control the disease.

This, I appreciate, sir, is a rather sketchy over-all picture. I do not want to go into more detail than you might wish.

Mr. KELLEY. Then the funds are adequate to take care of any effect of poliomyelitis in an epidemic such as this?

Dr. GUDAKUNST. Yes. In the present outbreak of the disease there are funds, freely available for the care of patients.

In North Carolina where an epidemic of infantile paralysis struck there were inadequate facilities to meet this disaster—and this was a disaster involving the nature of other catastrophic conditions, such as floods and earthquakes—additional hospital facilities had to be provided as quickly as possible. Temporary structures were erected, Army tents were secured, and a completely equipped hospital was put up in a period of 4 days.

As the number of cases increased more hospital facilities became necessary. They were provided at once. We built this temporary hospital in the Piedmont section of North Carolina, and there are now about 225 beds available there, with all the facilities and staff required. No patients are now waiting, and all are receiving the best of medical and nursing care.

The foundation has made available from its central funds about \$225,000 for that one job. That sum is in addition to the more than \$50,000 that was available in that area, held by the chapters. More money will be provided later as needed.

Also, in other areas in the United States this year where the needs for funds have exceeded the resources available immediately to the community, we have advanced our chapters such money as was needed.

Mr. KELLEY. The National Foundation for Infantile Paralysis is distinct from the Warm Springs Foundation?

Mr. GUDAKUNST. Yes. The Georgia Warm Springs Foundation is a separate foundation.

Mr. KELLEY. And they have no connection?

Dr. GUDAKUNST. They are separately incorporated and are separate organizations.

To say they have no connection would not be exactly true.

The National Foundation does make grants to the Georgia Warm Springs Foundation for its educational program. The majority of patients that are there have their medical and hospital care paid for by the chapters of the foundation, and any operating deficits that might be incurred because of extraordinary demands will be met by the National Foundation.

Mr. KELLEY. The Warm Springs Foundation is largely devoted to restoration; is it not?

Dr. GUDAKUNST. Yes; and it is a teaching center.

Mr. KELLEY. Is that the only one in the country?

Dr. GUDAKUNST. It is the only hospital set up exclusively for the treatment of infantile paralysis.

Mr. BARKER. What degree of control does the National Foundation exercise over the local chapters?

Dr. GUDAKUNST. They are branch organizations of the National Foundation operating under a charter by the national organization. The purposes for which they spend their funds are set up by the national organization for whom they spend it, and the details are not subject to control by the National Foundation.

Mr. BARKER. What about the staffs in the local chapters? Do they supply the professional people, or are they just people who take a voluntary interest in the subject?

Dr. GUDAKUNST. The chapters of the foundation are voluntary organizations. In only a comparatively few of the larger units do they have any paid personnel. That paid personnel is entirely clerical or managerial, and not a professional type. These chapters do not themselves employ physicians and nurses to work under chapter supervision. They do make funds available to the hospitals, clinics, and other agencies with which to employ such personnel.

Mr. BARKER. Does their work consist in the one phase of referring patients to hospitals and the furnishing of facilities rather than actually doing the work?

Dr. GUDAKUNST. Actually they do not do the work. These chapters are not treatment centers. There is some referral, but it is primarily an instrumentality that will make available to the official, voluntary agencies, the units such as hospitals and medical groups, the wherewithal with which to carry on their work.

They also engage in a very active and important educational program, constantly making available to the public knowledge as to what to do in an epidemic; or an individual person may want information in reference to treatment of infantile paralysis, why he should go to a doctor, where to go, and when to go, and how it can be paid for.

Mr. KELLEY. I am wondering whether voluntary workers are best qualified to make recommendations of that sort, whether it would not be better to have experts, if you could get them.

Dr. GUDAKUNST. The recommendations consist solely of advice of a general nature. These agencies, or these chapters, except in one or two instances, do not refer patients to a doctor, a hospital, or a clinic, as such. They do not have a list of preferred persons. That is the function of other agencies. If the health department or child-caring agencies do not have a proper referral staff, or an investigative staff, then the chapters do help those agencies in that problem. But, by and large, these lay people do not take upon themselves any phase of the practice of medicine.

Mr. KELLEY. Is it not true also that the local chapters cooperate with the officials of the Children's Bureau in their areas?

Dr. GUDAKUNST. The chapters do cooperate. This is specifically set forth in the instructions given to all chapters, and a part of their manual of organization is that they do work through and with the official agencies. There is no attempt to take over this whole problem. We have a big enough function without that.

Mr. KELLEY. From what we have heard this morning, it seems to me there is not anything lacking in the efforts to prevent the disease and to find the cure, and to restore patients afterward.

Dr. GUDAKUNST. I know of no other disease that is so adequately covered.

Mr. KELLEY. I was also impressed in that way.

Dr. GUDAKUNST. We have long since stopped referring to the unfortunate infantile paralysis patient. All of the patients, I think, are probably more fortunate than any others with so serious a disease.

Mr. KELLEY. I think that is true.

Mr. BARKER. What does the foundation do with reference to vocational rehabilitation?

Dr. GUDAKUNST. We have done almost nothing about it.

Mr. BARKER. There is an inadequacy of vocational rehabilitation in connection with the foundation; is there?

Dr. GUDAKUNST. I am sure I am not competent to speak on that subject; I have not studied it carefully.

Mr. BARKER. I think that is true. Is there any reason why the foundation does not go into that field? It apparently has enough money.

Dr. GUDAKUNST. Yes.

Mr. BARKER. And interest?

Dr. GUDAKUNST. We have the interest. There may be two reasons. We felt that we should concentrate our efforts on the imme-

diately urgent problems developing some means of prevention and of providing medical care.

Then the second reason is that there seemed to be in most localities some other agency that either could take over that problem or could be developed to take it over.

Neither one of those is a very strong reason, I recognize, but we just have not done any rehabilitation work. That does not mean that we will not do any.

Mr. KELLEY. Doctor, we appreciate very much your attendance this morning and the interesting and informative statement you have given us. We are very glad you have been with us.

Dr. GUDAKUNST. Thank you.

Mr. KELLEY. This will conclude the hearing today, and the committee will stand adjourned until 10 o'clock next Tuesday morning.

(Thereupon, the subcommittee adjourned to meet Tuesday, September 12, 1944 at 10 a. m.)

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